COUNTY OF LOS ANGELES –DEPARTMENT OF PUBLIC HEALTH
ALCOHOL AND DRUG PROGRAM ADMINISTRATION

Prevention Planning Meeting - October 8, 2009

Service Planning Area 5, 8, & 9 Regional Work Group Responses	
1. What are the alcohol and other drug (AOD) problems specifically affecting your community?	o Prescription drugs – especially impact on baby boomers/elderly; pharmacists are not adequately informing individuals of harmful/addictive qualities of some prescriptions. o In South Bay – easy access, density of alcohol outlets, problems with ethnic clubs not carding, easy access in the home, difficulty with discussing issue with parents due to boundary issues. o Understanding immigrant communities, acceptance of especially alcohol including presence and family/cultural events. o Lack of parent (Cambodian) knowledge of substance use issues and types of drugs used. o Torrance – denial of the substance use issues of youth, resistance of schools to allow prevention services/classroom education on-site and parents do not want schools to distribute information on tobacco use to students. o Need early intervention - start in middle schools not just high schools. o Access to appropriate prevention services o Parent/Community denial of problems and/or use of substances with parents o Lack of cultural and language services in Korean and Cambodian
2. How do you know it's a problem?	o Provider driven needs assessment, key informants, agencies are immersed in the communities served, discussion with participants/youth, focus groups o National data (YRBSS) and local school data (CHKS) inform efforts but some resist that it is a problem in their community or with their youth. o Programs with both prevention and treatment services are seeing an increase in treatment need. o ADPA provided data only on adults – need youth specific data especially on whether arrests were AOD related/impacted, school data/student data etc. o Seeing increase in participation by some ethnic/cultural groups not necessarily because of increased use but availability of bilingual staff.
3. What types of conditions or risk factors in your community contribute to these problems	o Increase number of Marijuana dispensaries o High alcohol outlet density (restaurants, bars, stores etc.) o Low cost of alcohol – tax increase needed but changes need to happen on a state level, need to increase advocacy and effect cheap prices. o Missing the link between alcohol and other social issues (e.g. arrests, domestic violence) and need to address the impact. o Deliberate advertising and promotional campaigns for alcohol (especially alcopops), product placement (e.g. Mike's Hard Lemonade – near sodas, appears nonalcoholic), store clerks and parents unaware of alcoholic contents of some drinks, stores selling to intoxicated persons. o Cultural acceptance and attitudes

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4. What types of community actions/programs already exist to prevent/reduce these problems?	o The agencies exist – and are present and participating in this process. o Organizing and collaboration o Media campaigns – environmental policies o Need to value individual level approaches, such as education strategies, skills building, group sessions, mentoring, parenting groups since they do impact behaviors and not just rely on environmental approaches. o Need to continue the availability of services that impact all parts of the IOM continuum – universal, selective, and indicated prevention. o Community events and mobilization.
5. Among the most serious problems, which three problems should be addressed first in consideration of available resources and community activities/programs?	o Availability and access of AOD o Social acceptability/social norms (across age groups and substances of choice) o Early onset – effort to delay onset of substance use
6. What type of evidence-based strategies should be considered for addressing alcohol and other drug problems?	o Concern over the definition of evidenced based practices (EBPs) – these were done in controlled environments, paid to have the program tested – and do not always take into account the various needs of the community and relying on EBPs can limit innovation. If used, providers need to be able to adapt models to specific client needs. o Communities should be allowed to define their own evidence and use that data as evidence in RFP applications. o Suggested "evidenced informed" versus "evidenced based" o Suggested strategies and models include: policy change, media efforts, youth development model, motivational interviewing, solution focused therapy, empowerment program – for HIV but could be adapted to AOD, and peer to peer model.
7. What are some key concepts and principles that should be considered for designing a prevention Request for Proposal (RFP) program design?	o ADPA must value what the agencies do – not just because they have been doing it for a long time but because the work done is what works in that community. o ADPA should respect the history of successful prevention strategies that have been used in various communities. o Agencies should not be mandated to do specific strategies but allowed the flexibility to respond to the changing needs and requests of the community. o Need social and/or environmental changes. o Need to also realize the value in individual level services. o Utilize the full continuum of prevention services – universal, selective, indicated. o Not all providers do environmental approaches, as their strengths are in of other strategies, but when approached for assistance (e.g. at Roundtable meetings) providers do support the environmental efforts (e.g. letter of support for legislation). o Providers agree to collaboration – already seeing an increase in collaborative efforts in recent years as you can accomplish more change as a group. o Need to see the link between AOD and other social issues, and address as such – understanding the impact of AOD use. o Need to be process oriented not just outcome oriented – need to understand how the field and program efforts have evolved over the years as some efforts/collaborations take time to develop and see change. This is not easily captured if only considering outcomes and not process – especially in reports. o Need to value qualitative not just quantitative data. o Need to respect the history and experience of providers – "never grab the initiative from the community"

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7. Continued	o Agencies have to help define what their successes are for prevention – need to be careful not to define success in the same manner as treatment services. o Outcomes can be individual/small scale not just population based.
8. What tools may assist your organization with preparing for the Request for Proposal process?	o Age specific data (youth, older adults) and only given treatment data. Need information on ER visits/hospitalizations, alcohol poisoning by age, police department data – especially if arrests are AOD related (unclear if currently collected – but should be), more specific information by race/ethnicity (e.g. cannot always group all API together). o Need a more realistic deadline – Spring 2010? Need to better inform providers on the timeline etc. so they are prepared. o Past ADPA contractual agreements, billing/reimbursement, and decision making have proven superior to other county departments.